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Sector-wide approaches and STI control in Africa

Allocation of aid from international agencies to the health sector in developing countries has usually involved funding of specific projects. This process enabled donors to suggest priorities and to monitor accountability of spending. More recently, a different system using sector-wide approaches (SWAps) has been adopted by an increasing number of funders including the World Bank, World Health Organization, and the Department for International Development. Through SWAps, funds are given to the entire health sector for priorities determined by ministries of health rather than to specific projects.[1] In theory the system should lead to greater efficiency through reduction of duplicative mechanisms that may occur through multiagency support.

Most of the UN agencies now recognise HIV increasingly as a societal problem. This belief would therefore seem to justify the allocation of HIV prevention funds to the whole health sector across the board. SWAps also appear justified by the contention that HIV/AIDS is associated with poverty and that the poor are more likely to access services that can be delivered at the primary healthcare level. Furthermore, this approach offers all HIV interested parties or stakeholders an opportunity to obtain funds from a central pool and have an input into HIV prevention strategies.

Serious doubts remain, however, about whether SWAps are effective.[2] No evaluation of SWAps in STI control has been undertaken. While the role of STI in preventing HIV is now well established, there are still conflicting opinions and uncertainty about how STI services for the population are best delivered. Clear policy directives are even more difficult to justify following the contrasting results of the Mwanza and Rakai studies in which both STI control strategies and the relative effects of the interventions differed significantly.[3 4] Given these uncertainties, will SWAps be a good idea for improving STI control in developing countries, and, more importantly, those communities with significant STI/HIV problems?

To answer this one must firstly look at the wider public health aspects of STI control and acknowledge the diversity of the HIV and STI epidemics. In Africa the prevalence of STIs appears to vary significantly between countries and populations. The prevalence of genital ulcer disease is higher in the countries worst affected by HIV in Africa.[5] Clearly, in some countries STI are a major problem and require a special focus while in others they are of lesser importance. In countries with significant STI/HIV epidemics, some of the potential concerns in adopting SWAps are as follows.

Lack of advocacy

In Africa there are few specialist physicians in STI/HIV. Historically, the majority of African countries have accorded little importance to STI in health budgets. This may reflect a state of denial and a belief that because STIs are not life threatening, individuals who brought such problems upon themselves did not merit special treatment and deserved to be punished for their immoral actions. Such notions are well established in many communities

and may be resistant to change, despite the recent evidence supporting STI interventions against HIV. If the project based approach is to be abandoned, ring fencing of funds for STI control activities may well be required.

The importance of advocacy is well demonstrated by the current situation in South Africa where local policymakers have adopted a low key approach to STI/ HIV/AIDS. HIV is still not accepted as a major problem despite antenatal prevalences of more than 30% in some provinces.[6] This denial at the highest governmental level is causing considerable distress and confusion among professionals working in the HIV field and the population at large.

Dilution of expertise

Responsibility for STI control may rest with a number of agencies including AIDS/HIV prevention, clinical services and reproductive health (RH), and others. The expanded concept of joint services for STI and RH has received strong political support, not least because they are directed mainly at women who are perceived to be victims of the HIV epidemic. However, in assessing whether integration is the way forward, limitations as well as benefits should be acknowledged.[7] While recognising that RH clinics may provide expertise designed for primary health care, they have little experience of providing specialised services for men. It is also worrying that the limited numbers of medical posts in STI have already been reduced in some areas following decentralisation of services.[8]

Targeting HIV core groups will be curtailed

Traditionally targeting has focused on groups such as sex workers and their clients, truck drivers and the military. As the epidemic expands out to the general population, new core groups at high risk of HIV must be identified in the community. One such group is STI clinic attenders—in some areas there is evidence that 77% of men with genital ulcers[9] and more than 60% of routine attenders are HIV positive.[10] STI services for men, a crucial group for targeting in urban settings, need dramatic improvement.[11] Designated clinics are also justified for a number of reasons, including enhanced surveillance, antibiotic susceptibility testing, training and education, referral of problem cases, evaluation of syndromic management protocols, and as a centre to develop expertise for an STI control programme.

A limited number of multisectoral STI interventions—for example, the Mwanza project, have been implemented usually through donor funding. The Mwanza intervention involved vertical and horizontal programmes but was undertaken in a rural population with a relatively low HIV prevalence for sub-Saharan Africa (4%). Whether the favourable results seen in this study would be replicated elsewhere in countries with worse HIV epidemics is unknown.

Providing scope for targeted interventions is a crucial component of a successful strategy for many countries.[12] However, SWAps are likely to limit the acceptance of targeting which is recognised as among the most cost effective strategies for STI/ HIV prevention. In Thailand, new STI clinics were opened and contributed to the success of the 100% condom use campaign. While the dynamics of the spread of HIV in Thailand are different in Africa, there is a strong case to be made for increasing the number of STI clinics in urban centres in the latter. In South Africa, targeted programmes for sex workers and miners brought about significant reductions in STI incidence.[13] Other established services for vulnerable and possibly illegal core groups such as sex workers, street kids, and injecting drug users could also suffer through SWAps. Again, ring fencing of funds by policymakers would appear to be necessary to assist these groups through STI and HIV prevention projects.

Supply and distribution of STI drugs

The importance of STI drugs in supporting a programme should not be underestimated. Drug shortages can quickly lead to both a loss of credibility of a programme and falling morale among service providers. Also, the potential for slippage (theft) of drugs may be considerable. Demand for STI drugs may be almost inexhaustible if used prophylactically. STI drugs provided for distribution to the whole health sector would be very difficult to track. Effective monitoring of drug use is paramount and should also be capable of standing up to rigid assessment through independent evaluation.

Conclusion

We are still not clear what is the best approach to improve STI control. The evidence base and what constitutes good governance in STI control varies significantly between populations. While SWAps support the horizontal approach to STI control by strengthening primary healthcare services, sometimes at the expense of designated specialist services, there is no evidence that this is the best strategy. Perhaps STI programme planners should take note of how health sector reform may affect tuberculosis control. Decentralisation of tuberculosis services into primary health care in Zambia has led to a marked reduction in funding and a deterioration in services for people with tuberculosis.[14] Optimal use of scarce resources for STI control probably requires a combination of approaches involving aspects of both the horizontal and vertical systems taking into account their strengths and weaknesses.[15 16] The tried and trusted methods in reducing STIs that have been poorly implemented in many African countries with severe STI/HIV problems should not be ignored in deference to SWAps until a full evaluation of its effectiveness has been undertaken.

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